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(e)	following: (a)Making dally reside and emotional status required nursing inter (b)Reviewing medical	be responsible for the ent visits to assess physical and implementing any vention; tion records for completeness, cription of physician orders, op-order policies;	L 051			

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 051 Continued From page 2 L 051 3210.4 Nursing Facilities Response A to findings - residents # 17, 109, & 130 appropriate goals and approaches, and revising them as needed: The identified Resident#17 had no notable negative 6/13/16 (d)Delegating responsibility to the nursing staff for outcomes with a systolic blood pressure <120mm HG. direct resident nursing care of specific residents: per Physician Orders (P.O.) Resident#17 had no notable/reported negative outcomes from receiving more than one eye drop medication at the same time. (e)Supervising and evaluating each nursing Licensed nurses were re-educated on monitoring blood employee on the unit; and pressure per physician orders in regard to specific medications and eye drop Administration. (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. Resident#109 had the antiblotic treatment reordered After the C-Diff culture report was obtained. Resident This Statute is not met as evidenced by: #130 was scheduled for surgery. MD orders requested medication to be held. Consulting Physician orders A. Based on observation, record review and staff needed clarification. Resident had no negative outcome due to medication being on hold. interview for three (3) of 36, stage 2 sampled residents, it was determined that the Charge Nurse A medical record audit was conducted for Resident 6/15/16 failed to ensure that each resident received the #17 including medication administration records was necessary care and services to attain or maintain also completed to ensure compliance with Physician orders for medication administrative the highest practicable physical, mental, and/or Parameters. No other residents identified with negative psychosocial well-being as evidenced by failure to: outcomes from eye drop administration. Resident#109 follow physician 's orders for the administration of a a medical record review of other residents with diuretic medication and administer eye medication diagnosis of C. Diff was conducted for compliance with according to manufacturer's specifications for one Physician orders. No other residents were identified. (1) resident; obtain a stool specimen for Clostridium Resident#130 a medical record review of other Difficile (C. Diff) in accordance with physician 's Residents with pre-op orders was conducted. No other orders for one (1) resident and clarify a preoperative orders required clarification from the Physician. order to withhold anticoagulant medications for one Consultative process reviewed and staff educated on resident. Residents #17, 109, and 130. Review of physician consult recommendations, Clarification of orders as indicated and final review by Manager signature to ensure full implementation. The findings include: 1. The Charge Nurse failed to follow physician's prescribed parameters for the administration of Resident #17 's diuretic medication, Furosemide [brand name Lasix]. [Diuretic - a medication that promotes the production of urine]. A review of Resident #17's History and Physical

Health Regulation & Licensing Administration

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L 051	2015 revealed his/he Retention, Dementia thrombosis), and HT Review of the April 2 (POS) directed, "F (1 tab [tablet] by mot for systolic blood pre The April 2016 Medic [MAR] revealed, "F by mouth every day than symbol] 120 "Furosemide 40 mg when his/her SBP with follows: April 3, 2016 - 112/April 4, 2016 - 113/April 6, 2016 - 116/April 11, 2016 - 11 April 13, 2016 - 11 April 14, 2016 - 11 April 14, 2016 - 11 April 18, 2016 - 11 April 18, 2016 - 11 April 23, 2016 - 10 April 24, 2016 - 10 April 25, 2016 - 10 April 26, 2016 - 10 April 27, 2016 - 10 April 27, 2016 - 11 April 28, 2016 - 11 April 30, 2016 - 11 April 30	by the physician October 14, er diagnoses included: Urinary I, Sarcoidosis, DVT (Deep Vein N (Hypertension). 2016 Physician 's order sheet urosemide 40mg tablet: Lasix at hevery day for Edema: hold essure less than 120). Cation Administration Record Furosemide 40mg (Lasix) 1 tab for Edema hold for SBP [less "The MAR revealed that was administered to the resident as less than 120 mmHg as 60 60 71 771 6/68 0/60 7/61 1/83 0/70 0/70 6/75 4/64 01/71 6/69 1/63 3/70 9/ (no diastolic reading	L 051	3210.4 Nursing Facilities (Cont'd) Response A to findings – residents # 17, 109 3. All Licensed staff was re-educated on Bes regarding medication administration. Staff educated on Lasix administration and BP Parameters. An audit tool was created to residents with BP parameters. All licensed staff was re-educated on adher physician orders in regard to specimen collection was also rewrith staff. Education with staff began on 6/13/16 regarded to the staff. Education with staff began on 6/13/16 regarded to understated an annual administration competency via demonstrated delity audit tool for reviewing labs will be defended to the QA Committee. Residents 8/11/16. Evening shift coordinator will conduct the Laboratory service log to ensure relab results and follow-up with action steps. Resident# 130 Report findings form consusting Reviews monthly to the QA Committee and determine if further interventions are neces Monitoring for compilance will be reported to Committee by the Director of Nursing until Compilance is met for 3 consecutive months.	t practices will be nonitor ring to lection and eviewed arding the leye ion and a eveloped. cted and le109 the luct review lecelpt of ltation lesary. to the QA 100%	7/20/16 6/13/16 6/13/16 8/11/16

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY L 051 Continued From page 4 L 051 Edema hold for SBP < 120 ... " The MAR revealed that Furosemide 40 mg was administered to Resident #17 when his/her SBP was less than 120 mmHg during the month of May as follows: May 1, 2016 - 119/ (no diastolic reading recorded), May 3, 2016 - 106/77 April 5, 2016 - 106/76 April 6, 2016 - 103/63 April 7, 2016 - 110/60 April 8, 2016 - 106/72 April 10, 2016 - 112/70 April 13, 2016 - 107/60 April 14, 2016 - 115/64 April 15, 2016 - 117/68 April 19, 2016 - 113/63 April 21, 2016 - 110/69 April 23, 2016 - 106/75 April 24, 2016 - 111/69 April 25, 2016 - 100/69 April 26, 2016 - 105/60 April 30, 2016 - 110/75 A review of the June 2016 "Physician's order sheet (POS) " directed. "Furosemide 40mg [milligram] tablet: Lasix (1 tab by mouth every day for Edema: hold for systolic blood pressure [SBP] less than 120). The June 2016 MAR revealed. "Furosemide 40mg (Lasix) 1 tab by mouth every day for Edema hold for SBP < 120 ... ". The MAR revealed that Furosemide 40 mg was administered to the resident when his/her SBP was less than 120 mmHg During the month of June as follows: June 1, 2016 - 100/65

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 051 Continued From page 5 L 051 June 2, 2016 -107/60 June 3, 2016 - 118/66 June 5, 2016 -115/65 June 6, 2016 - 118/60 June 8, 2016 -109/76 June 9, 2016 - 119/60 June 11, 2016 - 100/65 June 12, 2016 -105/71 June 13, 2016 - 107/57 A face-to-face interview was conducted with Employee #13 on June 13, 2016 at approximately 11:00 AM. He/she acknowledged that Lasix was administered to Resident #17 outside of prescribed parameters. The record was reviewed on June 13, 2016. 2. The Charge Nurse failed to administer Resident #17 's eye medications in accordance with manufacturer 's specifications. According to the manufacturer, Allergan, Inc. 's prescribing information, Brimonidine Tartrate Ophthalmic Solution, 0.15% is indicated for lowering intraocular pressure in patients with glaucoma. It may be used concomitantly with other topical ophthalmic drug products to lower intraocular pressure. " If more than one topical ophthalmic product is being used, the products should be administered at least 5 minutes apart ... " http://www.accessdata.fda.gov/drugsatfda docs/la bel/2012/021764s005lbi.pdf> According to the June 2016 physician 's orders, original order date of October 4, 2015 directed Brimomidine Tartrate 0.15% Drops (Instill 1 drop to each eye twice daily for Glaucoma; Dorzolamide - Timolol 22.3-6.8/1 Drops (Instill 1 drop in each eye twice daily for glaucoma.)

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		ation was conducted on June nately 10:35 AM with Employee as observed:	-			
	gloves, removed the cleansed the residen	ed (put on) a pair of nonsterile Resident #17 ' s glasses, it eye lids, removed gloves,	41.			
·	gloves, and retrieved Employee #13 admir	aced a clean pair of nonsterile I a facial tissue. At 10:40 AM histered 1 drop of Brimomidine is to each eye. At 10:42 AM				
	Employee #13 admir Dorzolamide-Timolol	nistered 1 drop of Employee #13 failed to wait leen the installation of the two				
2	container included a instructing "wait 5 meds [medications]. Dorzolamide-Timolol	e Brimomidine Tartrate storage label attached from pharmacy min [minutes] in between eye " The storage container for included a label from ructed " wait 5 minutes				
	2016 at approximatel and #13. Both acknowledge	ew was conducted on June 13, y 1:30 PM with Employees #3 owledged that Employee #13 iminutes between the drops.				
	specimen for Clostrid Difficile - an infection,	failed to obtain a stool ium Difficile (C. Diff or a bacterium that causes ce with physician 's orders for				
	A physician 's order on the second in the se	dated April 25, 2016 directed; bolic Panel) [May				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) L 051 Continued From page 7 L 051 2, 2016], Recheck stool for C. Difficile [May 2, 2016] ... Vancomycin oral 250mg via PEG (Percutaneous Endoscopic Gastrostomy) tube every 6 hours for C. Diff/Colitis ...stop order [Discontinue May 11, 20161..." A review of the April 2016 and May 2016 Medication Administration Record [MAR] revealed Resident #109 received Vancomycin 250mg via PEG tube every 6 hours for C.Diff/Colitis from April 25, 2016 to May 11, 2016. A review of the clinical record lacked evidence that the Charge Nurse followed through on the physician 's order to obtain the resident's stool specimen for C. Difficile. A face-to-face interview was conducted with Employees #5 and #10 on June 16, 2016 at approximately 4:00 PM regarding the lack of a stool specimen. Both acknowledged the stool culture was not obtained in accordance with the physician ' s order. The record was reviewed on June 16. 2016. 4. The Charge Nurse failed to clarify a preoperative order to withhold Aspirin and Levonox (the therapeutic use for both medications include, to help prevent the formation of blood clots) for Resident #130. A review of the June 2016 Physician 's Orders signed and dated by the physician on June 13, 2016 directed, "Aspirin chewable 81mg [tablet] via peg [percutaneous endoscopic gastrostomy tube] tube every day for anticoagulant; Lovenox 0.4 ml inject [subcutaneous] every day for anticoagulant "

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v of the "Acerative] Instructive aled, "Surpowing are impogery:Medions for (dayspirin)befor the instruction with through the endations)."	actions " form dated May 31, gery dated: June 15, 2016 portant steps to address before dications:Hold the following s) [this space was blank] re your surgery " The nexns, "Stop aspirin 6/1/16 [had a ne instruction] (per cardiologist should be some evidence that a specific				
e pre-op insi vithhold the a	tructions to direct the facility administration of Aspirin and				
	JB-ACUTE AN SUMMARY ST SEFICIENCY MUS' OR LSC IDE JEC From paging to the His by the physic as admitted with the followin , 2016, " Res l] on June 15 , 2016, " 4. e following max per cardiolo rementioned , 2016 were with the following are stration of Assurgery. W of the " Active Jenstruction where the instruction where the instruction where was of days was ne pre-op ins withhold the active Company was ne pre-op ins withhold the active Company was company was ne pre-op ins withhold the active Company was company was ne pre-op ins withhold the active Company was company was ne pre-op ins withhold the active Company was company was ne pre-op ins withhold the active Company was ne pre-op ins with the company was ne pre-op ins wi	PRESUPPLIER STREET AND REHAB SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Lied From page 8 Ing to the History and Physical examination by the physician August 28, 2015 Resident as admitted with diagnoses that included, ctomy [an opening cut into the skull] W of the facility's " Interim Order Forms " dithe following: 1, 2016, " Resident is scheduled for Implant on June 15, 2016 " 2016, " ASA [Aspirin] and Lovenox, and company are important steps to address before regery:Medications:Hold the following ions for (days) [this space was blank] spirin)before your surgery" The next he instructions, "Stop aspirin 6/1/16 [had a wn through the instruction] (per cardiologist rendations)." on, there was no evidence that a specific of days was recorded on the designated he pre-op instructions to direct the facility withhold the administration of Aspirin and	HFD02-0024 STREET ADDRESS, CITY, ST 700 CONSTITUTION A WASHINGTON, DC 2 SUMMARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Led From page 8 Ing to the History and Physical examination by the physician August 28, 2015 Resident as admitted with diagnoses that included, ctomy [an opening cut into the skull] w of the facility's " Interim Order Forms " d the following: , 2016, " Resident is scheduled for Implant i] on June 15, 2016 " , 2016, " 4. ASA [Aspirin] and Lovenox, e following medications for days ASA and x per cardiologist recommendation. werementioned pre-operative orders dated , 2016 were written without recording the of days the nurse was to withhold the stration of Aspirin and Lovenox prior to the surgery. w of the " Admission Testing -Pre-Op perative] Instructions " form dated May 31, evealed, " Surgery dated: June 15, 2016 powing are important steps to address before rigery:Medications:Hold the following ions for (days) [this space was blank] spirin)before your surgery" The next the instructions, "Stop aspirin 6/1/16 [had a wn through the instruction] (per cardiologist lendations). " on, there was no evidence that a specific of days was recorded on the designated he pre-op instructions to direct the facility withhold the administration of Aspirin and c	HFD02-0024 A SULDING: B. WING B. WING	HFD02-0024 B WING

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 051 Continued From page 9 L 051 3210.4 Nursing Facilities Administration Record revealed that: Response B to findings - resident # 32 Aspirin Chewable 81mg was signed with a nurse's Resident #32 had a skin alteration at the 5/6/16 tracheostomy site that healed prior to 6/17/16 initials [in the designated signature boxes] as given observation. Following Identification of the skin on June 1 and 2, 2016. The medication was not alteration at the tracheostomy site, a treatment plan signed as given and the word "Hold" was written had been developed by the facility. in the designated signature boxes during the period of June 3 through 15, 2016. Staff was in-serviced with Respiratory Techs 6/17/16 on preventing medical device-related pressure uicers. Levonox 0.4 ml sub-q every day for anticoagulant Clinical staff was re-educated on was given on June 1, 2016 and withheld from June Policy#CP-507 "Tracheostomy Care" on 2 through 15, 2016. 6/17/16. Nursing staff on the 6th floor were educated 6/17/16 regarding observation and assessment of There was no evidence that the Charge Nurse ostomy sites and surrounding skin. The Rehab communicated with the resident 's attending Department conducted an assessed the physician or the cardiologist to obtain and/or clarify residents and made recommendations for the exact number of days to withhold the turning and repositioning of cervical areas. administration of Aspirin and Levenox prior to June 15, 2016, the scheduled date of surgery. A head to toe skin check was conducted on all 7/6/16 residents with devices that could possibly cause an alteration on the skin. There were no new skin A face-to-face interview was conducted on June 15. alterations identified. 2016 at approximately 1:30 PM with Employee # 24. After reviewing the clinical record, he/she 3. acknowledged the findings. The record was Skin sheets were designed to include all 7/5/16 possible ostomy/medical device sites. A skin reviewed on June 15, 2016 sheet was customized for each resident specific areas of the body that are at risk for B. Based on observation, record review, and staff skin alteration. interviews for one (1) of 36 stage 2 sampled Skin assessments will be completed twice residents, it was determined that facility staff failed weekly and PRN on shower days. Both Nurses and Respiratory Therapist will to adequately assess Resident #32 's tracheal site collaborate on the skin assessment of the to ensure that necessary treatment and services tracheostomy site. Each discipline will were provided. Subsequently, the resident document their assessment. developed unstageable pressure ulcer(s) in the On 7/8/16 all Licensed Nurses were educated 7/8/16 tissues surrounding the trachea (peritracheal on proper assessment and documentation of the skin. region) that were initially assessed at advanced The IDT and Wound team met to confirm the 7/19/16 stages. Resident #32 protocol for skin integrity and wound management program. The findings include: Policy:

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DAT TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY L 051 Continued From page 10 L 051 3210.4 Nursing Facilities (Cont'd) Response B to findings - resident # 32 Tracheostomy Care, Policy Number: CP.507 effective date December 2014. Revision/Review Skin sheets will be audited weekly and immediate 8/11/16 Date: 2/2016 Stipulated, "Policy: A. Tracheostomy corrective action will be taken for newly identified sites will be reported during inter-shift report. Monthly care will be provided to tracheostomy tube, neck, audits will be conducted by the wound team. and stoma site B.I.D. (twice daily) and PRN [as needed! (for excessive discharge and/or grossly All findings will be reported to the QA Committee by soiled drain sponges), or as ordered by physician the Director of Nursing until 100% compliance is ... Procedure: B. Tracheostomy Care: ... 13. Examine consistently demonstrated for (3) months. neck and stoma for any breaks in skin integrity. Clinically competent staff member documents in appropriate area of patient's medical record. Documentation should include...4. Notification of any changes to patient 's nurse and attending physician and/or Pulmonologist ... " According to the "Comprehensive Physical Assessment " completed and signed by the registered nurse on April 22, 2016, Resident #32 was 82 years old, ventilator dependent and had diagnoses that included: respiratory failure, hypertension, debility, encephalopathy and status post cerebrovascular accident. The assessment included that the resident was "unaware of surroundings " and in a vegetative state. The History and Physical form signed and dated by the physician on April 23, 2016 revealed that Resident #32 's diagnoses included, CVA (Cerebrovascular accident) with encephalopathy and respiratory failure, HTN (hypertension), morbid obesity and that the resident 's skin was intact on admission. The admission Minimum Data Set (MDS) dated April 22, 2016 revealed: In Section C (Cognitive Patterns) the resident was coded as severely impaired.

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
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L 051	Continued From pag	je 11	L 051			
(1	1	
		unctional Status) the resident		1	i	-
		dependent, requiring		1		
		two people for bed mobility, et use, and personal hygiene.		1		
	diessing, eating, toil	et use, and personal hygiene.				
	in Section G0400 (I	Functional Limitation and Range				
		nt was coded as being			1	
	impaired on both sid extremities.	es (upper and lower)				
	extremities.					
	In Section I (Active D	Diagnoses) the resident was		l .		1
	coded as having " F	Respiratory failure, Trach				I
		ilator, Cerebrovascular	V.			
	Accident and Hypert	ension.				1
	Under Section M 015	60 the resident was coded as				
	being at risk for deve	loping pressure ulcers. In				
	Section M 0210 (Cur	rent Number of Unhealed			-	
*		resident was coded as "0" sident was admitted without				
1	pressure ulcers.	sident was admitted without			- 1	
J	•				1	
		ulcers/skin conditions" care				
	plan initiated on April	22, 2016 revealed		T.		
	(every) shift massag	ss skin integrity at least Q e around boney prominences,				
	turn and reposition Q	(2) two hours, pressure relief				
	mattress or specialty	skin assessments as on			1	
	admission, readmissi	on. Quarterlyand as needed.			Į.	
	A physician ' s teleph	one order dated May 6, 2016				ľ
		ed: "Cleanse left trach				
	(tracheostomy) site w	ound with nss (normal saline		1		
	solution) pat dry and	apply Skin Prep (Skin prep - a 📗		d.		
		essing that forms a protective				
	film to protect	dsource.com/product/skin-prep				
	-protective-dressing)	q [every] shift until seen				
7.7		- [3:3] Similarian Goon				

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX TAG TAG **DEFICIENCY**) L 051 Continued From page 12 L 051 by wound team ... Wound consult on 5/9/16." The clinical record lacked evidence of a comprehensive assessment of the resident's tracheal site wound to correlate with the physician ' s telephone wound treatment order of May 6, 2016. The nurse 's notes and physician notes lacked evidence of identification, characteristics (such as the stage, thickness, size etc.) and/or an assessment of an alteration in the skin integrity at the tracheal site to warrant obtaining an order for wound treatment on May 6, 2016. According to a physician 's progress note dated May 7, 2016: "Peritracheal Ulcer ... Post-surgical tracheal wound expanded due to pressure now unstageable ... " A nurse 's entry dated May 7, 2016 at 12 PM read: " ...wound treatment to trach site done. Right wound noted with 100% granulation tissue ø [no] drainage noted ... appeared dark ... " A nurse 's entry recorded May 7, 2016 at 11:30 AM, "SBAR [Situation Background Assessment Recommendation]/ Acute Change in condition report...two open areas noted on Trach site ... " An entry documented by the physician consultant on May 7, 2016 (no time entered) read as follows: "Wound Care Physician Assessment ... Etiology- post surgical; Side/Arrangement: peritracheal: duration [less than symbol] 10 days size 0.2 x 1.5 x 0.1cm; Drainage Serosanguinous; 50% granulation. " A physician 's order dated May 7, 2016 at 11:00 AM, directed: "Cleanse right open area with nss

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) L 051 Continued From page 13 L 051 pat dry, apply Xeroform (A sterile mesh gauze impregnated with a blend of 3% Bismuth Tribromophenate and Petrolatum) q daily until seen by wound team. "Wound and Skin Care According to the Progress Note" dated May 8, 2016, "Location Neck- Trach ... Characteristics etiology/ unstageable r/t(related to) medical device ... " A physician 's order dated May 9, 2016 at 2:40 PM. directed: "Trach site cleanse with wound cleanser. then apply Xeroform gauze daily. " A review of the Respiratory Therapist Notes and the Nursing Progress Notes from April 22 through from May 6, 2016 revealed that tracheal care was completed at minimum twice a day. According to a nurse 's note dated May 9, 2016 at 2:30 PM: "Seen by wound nurse for Trach site wound which measures 2x3 and necrotic ...wound is device induced pressure ulcer ...new order to clean with wound cleaner and apply Xeroform gauze o daily." According to the "Wound Care Physician" assessment form dated May 14, 2016 "Duration [less than symbol]10 days 'size 0.2 x 1.5 x 0.1cm 100 % necrosis." According to the "Wound and Skin Care Progress Note" dated May16, 2016, " Wound #1 Neck- Trach site: Characteristics etiology/ unstageable r/t [related to] medical device ...2 x 3 cm ...treatment: Xeroform gauze dressing daily as per order. Wound #2 location: Lt (left) side of the trach ... Characteristics etiology/ unstageable r/t medical device. Black dry eschar ...1x1.5 cm

Health Regulation & Licensing Administration

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 051	Continued From pag	e 14	L 051			
	treatment keep ope	en to air. "	0			
	Panel, "Pressure L Prevention," page a accurate staging of the	ional Pressure Ulcer Advisory Jicers in Adults: Predication and 2, "When eschar is present, he pressure ulcer is not char has sloughed or the wound				
· ·	10:00 AM lying in bed head flexed forward, shoulder, with a dres	eserved on June 14, 2016 at d on his/her back with his/her chin resting on the right sing observed in the d trach collar in place.				
	by the physician 's a 2016, "Rehabilitation	n of care included mabilitation services as directed dmitting orders dated April 22, n (rehab) Screen for PT (occupational therapy),				
ei .	April 25, 2016 and recurrently a rehab can vegetative state and p	rge to SNF (Skilled Nursing				
	Flow Sheets " the re	l and May 2016 "Restorative esident received Passive rcises for bilateral upper ral lower extremities.				
	2016 at approximately 24. When queried he flexes his/her head to	ew was conducted on June 17, y 11:30 AM with Employee # e/she stated the resident the right with her /his chin is caused the pressure on the lused the	į			

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING:_ B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 051 L 051 Continued From page 15 development of the pressure ulcer. He/she further stated that trach care is routinely done by the respiratory therapists. The employee acknowledged that there was no pressure relieving device or Interventions implemented to reposition the resident 's head/neck away from the trach collar after the pressure ulcers were detected. A face-to-face interview was conducted on June 17. 2016 at approximately 11:45 AM with Employee #21. When queried he/she stated respiratory does remove the inner cannula [of the trach] daily and He/she acknowledged that the resident flexes his/her head forward and placed pressure on the trach device. This placed him/her at risk for this type of breakdown and resident's skin is inspected daily during trach care. A face-to-face interview was conducted on June 20. 2016 at approximately 10:30 AM with Employee #18. He/she acknowledged that the resident was admitted without pressure sores to the trach area, and subsequently developed a two (2) unstageable areas below [underneath] the trach because of pressure from trach which was detected as unstageable before treatment was started. He/she was informed [of the pressure ulcer] by the respiratory therapist. He/she further acknowledged that no pressure relieving device(s) was implemented after the pressure ulcers developed. A face-to-face interview was conducted on June 22, 2016 at approximately 11:00 AM. Employee #19 was queried if the resident currently had one or more pressure ulcers? He/she responded, "Yes, the Trach area has an unstageable pressure ulcer from the Trach pushing against

Health R	Health Regulation & Licensing Administration						
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	l	·	1/10	DEFICIENCY)			
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2001		je io	1001	Ī			
	his/her skin. "						
i	Respiratory therapis	ts and registered nurses					
	recorded/documente	ed that tracheal care was done a					
		nily from April 22 through June					
		ere was no evidence that the day an alteration in the integrity of					
-		at the peritracheal region prior			,		
	to the development a	and detection of unstageable					
	pressure ulcers on M	May 6, 2016. The clinical record					
		t a comprehensive assessment ound(s) was conducted on May					
		ysician treatment orders were					
		f the Medication Administration					
		ay 2016 revealed that wound					
		ated on the 7:00 AM - 3:00 PM , and there was no record that					
*		med on May 6, 2016 when the					
		d. Lastly, once the resident was					
1	assessed with press	ure ulcers at the peritracheal					
ĺ	region and it was det	remined to have originated re and " device induced " ,					
-	there was no evidence	ce that facility staff					
	implemented pressur	re relieving measures such as a			1		
	head repositioning so	chedule and/or adaptive			1		
		ute or minimize the potential of the resident 's peritracheal			1	i	
(ii)	region.	in the resident is pentracheal					
	_						
TO DO		iew was conducted with the					
	approximately10:00	anager) on June 20, 2016 at AM. After a review of the					
		loyee #5 acknowledged the					
	aforementioned findir	ngs. The medical record was					
	reviewed on June 20	, 2016.	y.				
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Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 051 Continued From page 17 L 051 Cross referenced to 3211.1 L 052 3211.1 Nursing Facilities L 052 Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair: (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities: (f)Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair: (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating: (g)Prompt, unhurried assistance if he or she requires or request help with eating;

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECT!VE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY** L 052 Continued From page 18 L 052 3211.1 Nursing Facilities Response A to findings - resident #77 (h)Prescribed adaptive self-help devices to assist him or her in eating There were no residents affected by the result of this 6/18/16 independently; practice. An assessment was conducted on resident #77's ability to use other devices. A breath call beil system was ordered for resident on 6/18/16. (i)Assistance, if needed, with daily hygiene. Resident #77 and Staff were also educated on how including oral acre; and to use the breath call system. i)Prompt response to an activated call bell or call for A facility wide audit was conducted to identify other 6/20/16 help. residents who potentially have needs that require special accommodations. There were no negative findings of audit. This Statute is not met as evidenced by: Nursing staff will be educated on indicators for A. Based on observations and staff interviews for 8/11/16 accommodation (e.g. paraplegia, quadriplegia, one (1) of 36 stage 2 sampled residents, it was sensory deficits and adaptive devices). Care plans determined that facility staff failed to provide will also be created for residents with special needs Resident #77 with a call bell device to and interventions will include the possible use of accommodate his/her needs. Resident #77 special assistive devices. Unit Managers will conduct daily random audits to 8/11/16 The findings include: ensure call bell systems are appropriately placed and resident is able to access the mouth piece. A review of the quarterly Minimum Data Set completed May 7, 2016 revealed that under Section Monitoring for compliance will be reported to the QA I (Active Diagnoses) the resident was coded as Committee until 100% compliance is met for 3 Consecutive months. quadriplegic (paralysis; loss of use of all four limbs and torso). Under Section G (Functional Status) the resident was coded as totally dependent on staff for bed mobility, transfers, eating, dressing, toilet use, bathing and personal hygiene. A face-to-face interview was conducted with Resident #77 on June 17, 2016 at approximately 5:00 PM. Resident #77 stated, " ... I suffered a spinal cord injury about four (4) years ago and I am unable to move my arms ... ' Immediately following the interview, an observation of resident 's room was conducted. It was noted that Resident #77 had a 'push button' call bell placed next to his/her right arm.

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) L 052 Continued From page 19 L 052 The resident was asked if he/she could use it. He/she answered, "No, because I cannot move my arms ". The resident was asked; how do you ask for help when you need it? The resident replied, "I holler". On June 17, 2016 at approximately 5:40 PM a tour of the resident's room was conducted in the presence of Employee #2 (the Director of Nursing) and Employee #5 (the 6th floor unit manager). The resident was asked if he/she could press the button on his/her call bell. The resident replied that he/she was unable to do so as he/she is unable to move his/her arms. At this time a face-to-face interview was conducted with the manager of the unit. The manager was asked how does the staff know when the resident needs assistance. The manger stated, "He/she calls out to request help." There was no evidence that facility staff implemented measures and/or provided a device to accommodate Resident #77 's physical abilities as it relates to the use of a call system. B. Based on observation, record review and staff interview for three (3) of 36, stage 2 sampled residents, it was determined that the Charge Nurse failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by failure to: follow physician 's orders for the administration of a diuretic medication and administer eye medication according to manufacturer 's specifications for one (1) resident; obtain a stool specimen for Clostridium Difficile (C. Diff) in accordance with physician 's orders for one (1) resident and clarify a

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 052 L 052 Continued From page 20 3211.1 Nursing Facilities preoperative order to withhold anticoagulant Response B to findings - residents # 17, 109, & 130 medications for one (1) resident. Residents #17, The Identified Resident #17 had no notable negative 6/13/16 109, and 130, outcomes with a systolic blood pressure <120mm HG, per Physician Orders (P.O.) Resident #17 had The findings include: no notable/reported negative outcomes from receiving more than one eye drop medication at the same time. Licensed nurses were re-educated on 1. The Charge Nurse failed to follow physician's monitoring blood pressure per physician orders in prescribed parameters for the administration of regard to specific medications and eye drop Resident #17 's diuretic medication, Furosemide Administration. [brand name Lasix]. [Diuretic - a medication that promotes the production of urine]. Resident #109 had the antibiotic treatment reordered After the C-Diff culture report was obtained. Resident #130 was scheduled for surgery. MD A review of Resident #17's History and Physical orders requested medication to be held. Consulting examination signed by the physician October 14. Physician orders needed clarification. Resident had 2015 revealed his/her diagnoses included: Urinary no negative outcome due to medication being on Retention, Dementia, Sarcoidosis, DVT (Deep Vein hold. thrombosis), and HTN (Hypertension). A medical record audit was conducted for Resident 6/15/16 #17 including medication administration records was Review of the April 2016 Physician 's order sheet also completed to ensure compliance with (POS) directed, "Furosemide 40mg tablet: Lasix Physician orders for medication administrative (1 tab [tablet] by mouth every day for Edema: hold Parameters. No other residents identified with for systolic blood pressure less than 120). negative outcomes from eye drop administration. Resident#109 a medical record review of other residents with diagnosis of C. Diff was conducted for The April 2016 Medication Administration Record compliance with Physician orders. No other residents [MAR] revealed, "Furosemide 40mg (Lasix) 1 tab were identified. by mouth every day for Edema hold for SBP Iless Resident #130 a medical record review of other than symbol] 120 ... " The MAR revealed that Residents with pre-op orders was conducted. No Furosemide 40 mg was administered to the resident other orders required clarification from the Physician. when his/her SBP was less than 120 mmHg as Consultative process reviewed and staff educated on follows: Review of physician consult recommendations, Clarification of orders as indicated and final review by April 3, 2016 - 112/60 Manager signature to ensure full implementation. April 4, 2016 - 113/60 April 6, 2016 - 116/71 April 9, 2016 - 116/71 April 11, 2016 - 116/68 April 13, 2016 - 110/60 April 14, 2016 - 107/61 April 16, 2016 - 111/83

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) L 052 Continued From page 21 L 052 3211.1 Nursing Facilities (Cont'd) Response B to findings -- residents # 17, 109, & 130 April 18, 2016 -110/70 April 20, 2016 -110/70 All Licensed staff was re-educated on Best practices 7/20/16 April 23, 2016 -106/75 regarding medication administration. Staff will be April 24, 2016 -104/64 educated on Lasix administration and BP April 25, 2016 -101/71 Parameters. An audit tool was created to monitor Residents with BP parameters. April 26, 2016 -106/69 April 27, 2016 -111/63 All licensed staff was re-educated on adhering to 6/13/16 April 28, 2016 -113/70 physician orders in regard to specimen collection and April 30, 2016 -119/ (no diastolic reading process for specimen collection was also reviewed recorded) with staff. Education with staff began on 6/13/16 regarding the 6/13/16 The May 2016 MAR revealed, "Furosemide 40mg correct administration of eye drops. (Lasix) 1 tab by mouth every day for Edema hold for SBP < 120 ... " The MAR revealed that All licensed nurses will complete an annual eye 8/11/16 Furosemide 40 mg was administered to Resident administration competency via demonstration and a #17 when his/her SBP was less than 120 mmHg daily audit tool for reviewing labs will be developed. during the month of May as follows: Resident #17 monthly audits will be conducted and 8/11/16 Reported to the QA Committee, Resident#109 the May 1, 2016 - 119/ (no diastolic reading recorded), 8/11/16. Evening shift coordinator will conduct review May 3, 2016 - 106/77 dally the Laboratory service log to ensure receipt of April 5, 2016 - 106/76 lab results and follow-up with action steps. April 6, 2016 - 103/63 Resident #130 Report findings form consultation April 7, 2016 - 110/60 Reviews monthly to the QA Committee and April 8, 2016 - 106/72 determine if further interventions are necessary. April 10, 2016 - 112/70 April 13, 2016 - 107/60 Monitoring for compliance will be reported to the QA Committee by the Director of Nursing until 100% April 14, 2016 - 115/64 Compliance is met for 3 consecutive months. April 15, 2016 - 117/68 April 19, 2016 - 113/63 April 21, 2016 - 110/69 April 23, 2016 - 106/75 April 24, 2016 - 111/69 April 25, 2016 - 100/69 April 26, 2016 - 105/60 April 30, 2016 - 110/75 A review of the June 2016 "Physician's order sheet (POS) " directed, "Furosemide 40mg

Health Regulation & Licensing Administration

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	[milligram] tablet: La for Edema: hold for s less than 120).	six (1 tab by mouth every day systolic blood pressure [SBP]				
	40mg (Lasix) 1 tab b	revealed, "Furosemide y mouth every day for Edema				
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	when his/her SBP wa the month of June as	as less than 120 mmHg During				
	June 1, 2016 - 100/ June 2, 2016 - 107					
	June 3, 2016 - 118 June 5, 2016 - 115					
÷:	June 6, 2016 - 118 June 8, 2016 - 109	/60				
	June 9, 2016 - 119 June 11, 2016 - 10	/60				
	June 12, 2016 - 10					J
		ew was conducted with				
	Employee #13 on Jur	ne 13, 2016 at approximately acknowledged that Lasix was				
	administered to Resid	dent #17 outside of prescribed cord was reviewed on June 13,				
	The Charge Nurse #17 's eye medication manufacturer 's spec	e failed to administer Resident ns in accordance with ifications.				
	prescribing informatio Ophthalmic Solution, intraocular pressure in	ufacturer, Allergan, Inc. 's n, Brimonidine Tartrate 0.15% is indicated for lowering n patients with glaucoma. It itantly with other topical				
	-p.m.m.mo drug produ	2010 10 101101				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) L 052 Continued From page 23 L 052 intraocular pressure. " If more than one topical ophthalmic product is being used, the products should be administered at least 5 minutes apart ... " http://www.accessdata.fda.gov/drugsatfda_docs/la bel/2012/021764s005lbl.pdf> According to the June 2016 physician 's orders, original order date of October 4, 2015 directed Brimomidine Tartrate 0.15% Drops (Instill 1 drop to each eye twice daily for Glaucoma: Dorzolamide - Timolol 22.3-6.8/1 Drops (Instill 1 drop in each eye twice daily for glaucoma.) A medication observation was conducted on June 13, 2016 at approximately 10:35 AM with Employee #13, the following was observed: Employee #13 donned (put on) a pair of nonsterile gloves, removed the Resident #17's glasses. cleansed the resident eve lids, removed gloves. washed hands, replaced a clean pair of nonsterile gloves, and retrieved a facial tissue. At 10:40 AM Employee #13 administered 1 drop of Brimomidine Tartrate 0.15% drops to each eye. At 10:42 AM Employee #13 administered 1 drop of Dorzolamide-Timolol. Employee #13 failed to wait five (5) minutes between the installation of the two (2) different eye drop solutions. An observation of the Brimomidine Tartrate storage container included a label attached from pharmacy instructing "wait 5 min [minutes] in between eye meds [medications] ... " The storage container for Dorzolamide-Timolol included a label from pharmacy which instructed "wait 5 minutes between meds ... " A face-to-face interview was conducted on June 13, 2016 at approximately 1:30 PM with

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X5) COMPLETE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) L 052 Continued From page 24 L 052 Employees #3 and #13. Both acknowledged that Employee #13 should have waited 5 minutes between the administration of eye drops. 3. The Charge Nurse failed to obtain a stool specimen for Clostridium Difficile (C. Diff or Difficile - an infection, a bacterium that causes diarrhea) in accordance with physician 's orders for Resident #109. A physician 's order dated April 25, 2016 directed; ... BMP (Basic Metabolic Panel) [May 2, 2016], Recheck stool for C. Difficile [May 2, 2016] ... Vancomycin oral 250mg via PEG (Percutaneous Endoscopic Gastrostomy) tube every 6 hours for C. Diff/Colitis ...stop order [Discontinue May 11. 2016]... " A review of the April 2016 and May 2016 Medication Administration Record [MAR] revealed Resident #109 received Vancomycin 250mg via PEG tube every 6 hours for C.Diff/Colitis from April 25, 2016 to May 11, 2016. A review of the clinical record lacked evidence that the Charge Nurse followed through on the physician 's order to obtain the resident's stool specimen for C. Difficile. A face-to-face interview was conducted with Employees #5 and #10 on June 16, 2016 at approximately 4:00 PM regarding the lack of a stool specimen. Both acknowledged the stool culture was not obtained in accordance with the physician ' s order. The record was reviewed on June 16, 2016. 4. The Charge Nurse failed to clarify a

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 052 Continued From page 25 L 052 preoperative order to withhold Aspirin and Levonox (the therapeutic use for both medications include, to help prevent the formation of blood clots) for Resident #130. A review of the June 2016 Physician 's Orders signed and dated by the physician on June 13, 2016 directed, "Aspirin chewable 81mg [tablet] via peg [percutaneous endoscopic gastrostomy tube] tube every day for anticoagulant; Lovenox 0.4 ml inject [subcutaneous] every day for anticoagulant " According to the History and Physical examination signed by the physician August 28, 2015 Resident #130 was admitted with diagnoses that included. Craniectomy [an opening cut into the skull] A review of the facility's " Interim Order Forms " directed the following: May 23, 2016, "Resident is scheduled for Implant [Cranial] on June 15, 2016 " May 25, 2016, " 4. ASA [Aspirin] and Lovenox, hold the following medications for days ASA and Lovenox per cardiologist recommendation. The aforementioned pre-operative orders dated May 25, 2016 were written without recording the number of days the nurse was to withhold the administration of Aspirin and Lovenox prior to the day of surgery. A review of the "Admission Testing -Pre-Op [pre-operative] Instructions " form dated May 31, 2016 revealed, "Surgery dated: June 15, 2016 ... The following are important steps to address before your surgery: ... Medications: ... Hold the

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		s for (days) [this space wasbefore your surgery "				
		instructions, "Stop aspirin				1
		awn through the instruction]		i		
	(per cardiologist reco	ommendations). "				
	in addition, there wa	s no evidence that a specific				
		recorded on the designated				
		tructions to direct the facility				
		administration of Aspirin and				
	Levonox					
Y	A review of the June	2016 Medication				ļ I
	Administration Reco	rd revealed that:				1
	Asnirin Chewahle 81	mg was signed with a nurse's				
		ated signature boxes] as given				l !
	on June 1 and 2, 201	The medication was not				
	signed as given and	the word "Hold" was written				
1	of June 3 through 15	nature boxes during the period				
-	or danc o undagir ro	, 2010.				
- 1		q every day for anticoagulant				
		, 2016 and withheld from June				
ì	2 through 15, 2016.					ŀ
	There was no eviden	ce that the Charge Nurse				
	communicated with ti	he resident 's attending				
		iologist to obtain and/or clarify				İ
	the exact number of a	days to withhold the irin and Levenox prior to June				
	15, 2016, the schedu	lled date of surgery.				
357						ŀ
		ew was conducted on June 15,				
	After reviewing the cl	y 1:30 PM with Employee # 24.				
		inical record, ne/she				
	reviewed on June 15					
	O Beard on the control	Atam and and and and are				
7.	U. Based on observa	tion, record review, and staff				

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L 052	interviews for one (1 residents, it was dete to adequately assess to ensure that neces were provided. Subdeveloped unstagea tissues surrounding region) that were init stages. Resident #37. The findings included Policy: Tracheostomy Care, effective date Decembate: 2/2016 Stipula care will be provided and stoma site B.I.D needed] (for excessisoiled drain sponges Procedure: B. Tracheostomy competent appropriate area of procumentation should any changes to patie physician and/or Pull According to the "Cassessment" compregistered nurse on Awas 82 years old, vediagnoses that including post cerebrovascular	of 36 stage 2 sampled ermined that facility staff failed is Resident #32 's tracheal site sary treatment and services osequently, the resident ble pressure ulcer(s) in the the trachea (peritracheal ially assessed at advanced 2 Policy Number: CP.507 ober 2014, Revision/Review ted, "Policy: A. Tracheostomy to tracheostomy tube, neck, (twice daily) and PRN [as we discharge and/or grossly), or as ordered by physician sheostomy Care:13. Examine any breaks in skin integrity. staff member documents in settlent 's medical record. It include4. Notification of soft 's nurse and attending monologist "Comprehensive Physical pleted and signed by the April 22, 2016, Resident #32 of the properties of the properties of the second of the comprehensive physical pleted and signed by the April 22, 2016, Resident #32 of the properties of the properties of the assessment decircular was "unaware of the properties of the properties of the properties of the assessment dent was "unaware of the properties of the properti	L 052				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) L 052 Continued From page 28 L 052 The History and Physical form signed and dated by the physician on April 23, 2016 revealed that Resident #32 's diagnoses included, CVA (Cerebrovascular accident) with encephalopathy and respiratory failure, HTN (hypertension), morbid obesity and that the resident 's skin was intact on admission. The admission Minimum Data Set (MDS) dated April 22, 2016 revealed: In Section C (Cognitive Patterns) the resident was coded as severely impaired. In Section G0110 (Functional Status) the resident was coded as totally dependent, requiring assistance of one or two people for bed mobility, dressing, eating, toilet use, and personal hygiene. In Section G0400 (Functional Limitation and Range of Motion) the resident was coded as being impaired on both sides (upper and lower) extremities. In Section I (Active Diagnoses) the resident was coded as having "Respiratory failure, Trach [tracheostomy], Ventilator, Cerebrovascular Accident and Hypertension. Under Section M 0150 the resident was coded as being at risk for developing pressure ulcers. In Section M 0210 (Current Number of Unhealed Pressure Ulcers) the resident was coded as "0" indicating that the resident was admitted without pressure ulcers. The "Pressure/stasis ulcers/skin conditions" care plan initiated on April 22, 2016 revealed "Interventions: assess skin integrity at least Q (every) shift, massage around boney

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
L 052	Continued From pag	e 29	L 052			
	pressure relief mattre	nd reposition Q (2) two hours, ess or specialty, skin admission, readmission. eeded.				
φ.	[no time noted] directoracheostomy) site was solution) pat dry and liquid film-forming drafilm to protect skinhttp://www.woun-protective-dressing)	none order dated May 6, 2016 ted: "Cleanse left trach wound with nss (normal saline apply Skin Prep (Skin prep - a essing that forms a protective dsource.com/product/skin-prep q [every] shift until seen by d consult on 5/9/16."				
e e	tracheal site wound to stelephone wound to The nurse 's notes a evidence of identificatine stage, thickness, assessment of an alto	ssment of the resident 's o correlate with the physician 'reatment order of May 6, 2016. and physician notes lacked ation, characteristics (such as size etc.) and/or an eration in the skin Integrity at arrant obtaining an order for				
986	May 7, 2016: "Peritr	cian ' s progress note dated racheal UlcerPost-surgical nded due to pressure now				
	"wound treatment t	od May 7, 2016 at 12 PM read: to trach site done. Right wound nulation tissue ø [no] drainage rk"				
	AM, "SBAR [Situati	rded May 7, 2016 at 11:30 on Background Assessment cute Change in condition				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 052 Continued From page 30 L 052 report...two open areas noted on Trach site ... " An entry documented by the physician consultant on May 7, 2016 (no time entered) read as follows: "Wound Care Physician Assessment ... Etiology- post surgical; Side/Arrangement: peritracheal: duration [less than symbol] 10 days size 0.2 x 1.5 x 0.1cm; Drainage Serosanguinous; 50% granulation. " A physician 's order dated May 7, 2016 at 11:00 AM, directed: "Cleanse right open area with nss pat dry, apply Xeroform (A sterile mesh gauze Impregnated with a blend of 3% Bismuth Tribromophenate and Petrolatum) q daily until seen by wound team. According to the " Wound and Skin Care Progress Note" dated May 8, 2016, "Location Neck- Trach ... Characteristics etiology/ unstageable r/t(related to) medical device ... " A physician 's order dated May 9, 2016 at 2:40 PM. directed: "Trach site cleanse with wound cleanser. then apply Xeroform gauze daily. " A review of the Respiratory Therapist Notes and the Nursing Progress Notes from April 22 through from May 6, 2016 revealed that tracheal care was completed at minimum twice a day. According to a nurse 's note dated May 9, 2016 at 2:30 PM: "Seen by wound nurse for Trach site wound which measures 2x3 and necrotic ...wound is device induced pressure ulcer ...new order to clean with wound cleaner and apply Xeroform gauze q daily."

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 052 Continued From page 31 L 052 According to the "Wound Care Physician" assessment form dated May 14, 2016 "Duration [less than symbol]10 days 'size 0.2 x 1.5 x 0.1cm 100 % necrosis." According to the "Wound and Skin Care Progress Note" dated May16, 2016, "Wound #1 Neck- Trach site: Characteristics etiology/ unstageable r/t [related to] medical device ... 2 x 3 cm ...treatment: Xeroform gauze dressing daily as per order. Wound #2 location: Lt (left) side of the trach ... Characteristics etiology/ unstageable r/t medical device. Black dry eschar ...1x1.5 cm ...treatment keep open to air. " According to the National Pressure Ulcer Advisory Panel, "Pressure Ulcers in Adults: Predication and Prevention, " page 2, "When eschar is present, accurate staging of the pressure ulcer is not possible until the eschar has sloughed or the wound has been debrided." Resident #32 was observed on June 14, 2016 at 10:00 AM lying in bed on his/her back with his/her head flexed forward, chin resting on the right shoulder, with a dressing observed in the peritracheal area and trach collar in place. Resident #32 's plan of care included assessment(s) by rehabilitation services as directed by the physician 's admitting orders dated April 22. 2016, "Rehabilitation (rehab) Screen for PT (physical therapy) OT (occupational therapy). Speech therapy..." An Occupational Therapy Screen was conducted on April 25, 2016 and revealed, "Pt (patient) is not currently a rehab candidate. Pt is dependent in a vegetative state and presents with no contractures...Discharge to SNF (Skilled Nursing

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 052 Continued From page 32 L 052 Facility) unit on restorative program." According to the April and May 2016 "Restorative Flow Sheets " the resident received Passive Range of Motion exercises for bilateral upper extremities and bilateral lower extremities. A face-to-face interview was conducted on June 17, 2016 at approximately 11:30 AM with Employee # 24. When queried he/she stated the resident flexes his/her head to the right with her /his chin pointed down and this caused the pressure on the trach device which caused the development of the pressure ulcer. He/she further stated that trach care is routinely done by the respiratory therapists. The employee acknowledged that there was no pressure relieving device or interventions implemented to reposition the resident 's head/neck away from the trach collar after the pressure ulcers were detected. A face-to-face interview was conducted on June 17. 2016 at approximately 11:45 AM with Employee #21. When queried he/she stated respiratory does remove the inner cannula [of the trach] daily and replace it. He/she acknowledged that the resident flexes his/her head forward and placed pressure on the trach device. This placed him/her at risk for this type of breakdown and resident 's skin is inspected daily during trach care. A face-to-face interview was conducted on June 20, 2016 at approximately 10:30 AM with Employee #18. He/she acknowledged that the resident was admitted without pressure sores to the trach area. and subsequently developed a two (2) unstageable areas below [underneath] the trach because of pressure from trach which was

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 052 Continued From page 33 L 052 detected as unstageable before treatment was started. He/she was informed [of the pressure ulcer] by the respiratory therapist. He/she further acknowledged that no pressure relieving device(s) was implemented after the pressure ulcers developed. A face-to-face interview was conducted on June 22. 2016 at approximately 11:00 AM. Employee #19 was queried if the resident currently had one or more pressure ulcers? He/she responded, "Yes, the Trach area has an unstageable pressure ulcer from the Trach pushing against his/her skin. " Respiratory therapists and registered nurses recorded/documented that tracheal care was done a minimum of twice daily from April 22 through June 6, 2016, however, there was no evidence that the facility staff assessed an alteration in the integrity of the resident's skin at the peritracheal region prior to the development and detection of unstageable pressure ulcers on May 6, 2016. The clinical record lacked evidence that a comprehensive assessment of the peritracheal wound(s) was conducted on May 6, 2016, the date physician treatment orders were obtained. A review of the Medication Administration Record [MAR] for May 2016 revealed that wound treatments were initiated on the 7:00 AM - 3:00 PM shift on May 7, 2016, and there was no record that treatment was performed on May 6, 2016 when the orders were obtained. Lastly, once the resident was assessed with pressure ulcers at the peritracheal region and it was determined to have originated secondary to pressure and "device induced". there was no evidence that facility staff implemented pressure relieving measures such as a head repositioning schedule and/or adaptive

PRINTED: 07/19/2016 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 052 Continued From page 34 L 052 device(s) to redistribute or minimize the potential pressure at the site of the resident's peritracheal region. A face-to- face interview was conducted with the Employee #5 (Unit Manager) on June 20, 2016 at approximately10:00 AM. After a review of the medical record, Employee #5 acknowledged the aforementioned findings. The medical record was reviewed on June 20, 2016. Cross referenced to 3210.4 L 091 3217.6 Nursing Facilities L 091 3217.6 Nursing Facilities Response to findings - resident # 17 The Infection Control Committee shall ensure that Staff Involved completed a just-in-time education and 6/13/16 infection control policies and procedures are were coached on the proper protocols for hand implemented and shall ensure that environmental hyglene related to Infection control. services, including housekeeping, pest control. All residents are at risk for infection due to improper laundry, and linen supply are in accordance with the hand hyglene. requirements of this chapter. Staff will wash hands prior to entering resident room This Statute is not met as evidenced by: and upon exiting resident room, Based on observations and and staff interview for All hand sanitizers will be relocated outside of the 8/11/16 two (2) of 36 stage 2 sampled residents, it was resident's room. determined that facility staff failed to practice hand A self-learning packet with a test was distributed to all 6/19/16 hygiene in accordance accepted standards of clinical staff. All clinical staff will complete a return practice during a medication administration demonstration competency. observation a wound treatment observation for two Random handwashing observations using the (2) residents. Residents #17 and 115. 'Shoppers' program will be done monthly. All findings will be reported to the QA committee by the infection The findings include: Control Coordinator until 100% compliance is consistently maintained for three months. According to Centers for Disease Control and

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Prevention handwashing guidelines are as follows:

"Wet your hands with clean, running water ... Lather your hands by rubbing them together with the soap.

Be sure to lather the backs of your

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 099 Continued From page 37 L 099 3219.1 Nursing Facilities (Cont'd) Response to finding # 5 their expiration date of March 2016. 1. The Identified solled fryer was Immediately cleaned. 6/13/16 2. Director of Food Services conducted an audit of all 6/13/16 The findings include: soiled equipment and other equipment used with no negative findings. 14 of 14 fruit bowls of honeydew and 23 of 23 Staff was in-serviced on the daily expectations of salad bowls were stored in the reach-in cooler box 6/14/16 ensuring that all pellet warmer and fryers are #3 and were not labeled or dated. thoroughly cleaned. 2. One (1) of one (1) food warmer was soiled at Director of Food Services will conduct a weekly audit the bottom with leftover food residue. of all equipment to ensure Items are cleaned and auditing tool signed. 3. 36 of 36 four-ounce cartons of fat free skim milk The Director of Food Services will monitor for stored in the reach-in cooler box #3 were expired as compliance and report to the QA Committee until of June 12, 2016. 100% compliance is met for 3 consecutive months. 4. The door handle to one (1) of two (2) convection ovens was loose. 3219.1 Nursing Facilities (Cont'd) Response to finding #6 5. The pellet warmer from the 'Heat Demand' Director of Food Services immediately discarded the 1. 6/13/16 heating system and one (1) of two (2) grease fryers dented cooking pots and sifters. were soiled. 2, Director of Food Services conducted an audit of all 6/14/16 equipment and utensils. No other dented Items were 6. Two (2) of five (5) cooking pots and two (2) of identified during this audit. two (2) sifters were dented throughout. Director of Food Services Implemented an audit tool 6/14/16 7. Two (2) of two (2) eyewash bottles from the for assessing/monitoring the quality use of equipment. eyewash station in the dishwashing area were Director of Food Services will conduct monthly expired as of March 2016. inspections of equipment and smallwares to ensure no dented Items are on site. These observations were made in the presence of Employee #8 who acknowledged the findings. All findings will be reported to the QA Committee by the Director of Food Services until 100% compliance is consistently maintained for three months. L 200 3231.11 Nursing Facilities L 200 Each entry into a medical record shall be legible. current, in black ink, dated and signed with full

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Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 099 Continued From page 37 L 099 3219.1 Nursing Facilities (Cont'd) Response to finding #7 their expiration date of March 2016. The expired products were discarded. Director of Food 6/13/16 Services implemented a monthly audit tool to view expiration dates of the eyewash stations. The findings include: Director of Food Services conducted an audit to 6/13/16 1. 14 of 14 fruit bowls of honeydew and 23 of 23 determine if other evewash stations contained expired salad bowls were stored in the reach-in cooler box solutions. No other eyewash stations contained expired solution. #3 and were not labeled or dated. Director of Food Services will conduct an Internal 6/13/16 One (1) of one (1) food warmer was soiled at monthly inspection of the eye wash stations. All staff the bottom with leftover food residue. were educated on the monitoring of eyewash stations on 6/13/16. 3. 36 of 36 four-ounce cartons of fat free skim milk 4. All monthly inspection findings will be reported to the stored in the reach-in cooler box #3 were expired as QA committee by the Director of Food Services until of June 12, 2016. 100% compliance is consistently maintained for three months. 4. The door handle to one (1) of two (2) convection ovens was loose. 5. The pellet warmer from the 'Heat Demand' heating system and one (1) of two (2) grease fryers were soiled. 6. Two (2) of five (5) cooking pots and two (2) of two (2) sifters were dented throughout. 7. Two (2) of two (2) eyewash bottles from the eyewash station in the dishwashing area were expired as of March 2016. These observations were made in the presence of Employee #8 who acknowledged the findings. L 200 3231.11 Nursing Facilities L 200 Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification.

This Statute is not met as evidenced by:

FORM APPROVED Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX DATE OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) L 200 L 200 Continued From page 38 3231.11 Nursing Facilities Response to findings - resident #89 Based on record review and staff interview for one Resident #89 medical record cannot be corrected. (1) of 36 stage 2 sampled residents, it was 7/8/16 determined that facility staff failed to document the A review of other residents wound documentation stage of Resident #89 's wound on the " Weekly was conducted. Wound notes were updated by the Wound Documentation" sheet. Resident #89. wound team. All nursing staff will be educated on the proper The findings include: 8/11/16 assessment and documentation of the skin. Facility staff falled to document the stage of the A wound meeting was held on 7-19-16 with the 7/19/16 wound on the "Weekly Wound Documentation" wound interdisciplinary team to confirm the system for sheet for Resident #89. the skin integrity/wound management program. Monthly random audits of the skin/wound section of A review of the "Weekly Wound Documentation" the medical record; all findings will be reported by the form dated May 30, 2016 revealed that Resident Director of Nursing or Designee to the QA Committee #89 had a community acquired sacral ulcer. On until 100% compilance is consistently maintained for May 30 and June 6, 2016 there was no " three months. Stage/Thickness " recorded on the form to convey the extent of the tissue damage to the wound. According to the "Wound and Skin Care Progress Note" completed by the facility 's wound team, the stage/thickness of the sacral wound on May 30 and June 6, 2016 was "Unstageable". A face-to-face interview was conducted with Employee #24 on June 14, 2016 at approximately 11:16 AM. After reviewing the form Employee #24 acknowledged the findings. Facility staff failed to document the stage/thickness of Resident's sacral ulcer on the "Weekly Wound Documentation " form. The record was reviewed on June 14, 2016.

L 214 3234.1 Nursing Facilities

Each facility shall be designed, constructed,

SZBL11

L 214

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: HFD02-0024 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L 214 Continued From page 39 L 214 3234.1 Nursing Facilities Response to findings 1 - 3 located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and Maintenance took Immediate action to tighten and 7/16/16 repair all identified loose handrails. All identified loose supportive environment for each resident, employee or missing floor tiles were properly secured and surge and the visiting public. protectors were properly secured to wails. This Statute is not met as evidenced by: A complete facility audit was conducted to assess any 7/13/16 Based on observations made on June 16, 2016 potential accident hazards within the environment. between 10:00 AM and 2:00 PM, it was determined that the facility failed to maintain resident The Director of Plant Operations conducted training 7/15/16 environment free of accident hazards as evidenced with both EVS and Maintenance staff maintaining an environment that is free of accident hazards. Monthly by damaged handrails on two (2) of three (3) EOC Rounds will be conducted by the Director of resident care units, loose or missing floor tiles in Plant Operations. three (3) of 37 resident rooms, and surge protectors that were not properly secured in two (2) of 37 Monitoring for compilance will be reported to the QA resident rooms surveyed. committee by the Director of Plant Operations until 100% compliance is met for 3 consecutive months. The findings include: 1. The handrail located in front of room #5142 and the handrail located in front of room #4132 were both missing an end cap, and their sharp edges were exposed to residents, staff and visitors. 2. Floor tiles were either loose or missing in resident room # 6139, #4154 and #4130, and posed a tripping hazard in three (3) of 37 resident rooms surveyed. Surge protectors were not mounted in resident's room #6142 and #5113, two (2) of 37 resident 's rooms surveyed. These observations were made in the presence of Employee #9 who acknowledged the findings. F323 L 292 3243.3 Nursing Facilities L 292

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

WASHINGTON, DC 20002

FORM APPROVED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) DENTIFICATION NUMBER: STREET ADDRESS, CITY, STATE, ZIP CODE

700 CONSTITUTION AVE. NE

WASHINGTON, DC 20002

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)

	WASHING	10N, DC 2	0002	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 292	Continued From page 40 Each ramp, stairway,and corridor that is used by a resident shall be equipped with firmly secured handrails or banisters on each side. This Statute—is not met as evidenced by: Based on observations made on June 16, 2016 between 10:00 AM and 2:00 PM, it was determined that the facility failed to ensure that handrails are firmly secured in corridors as evidenced by loose handrails on one (1) of three (3) resident units. The findings include: The handrails located across from room #6144 and next to the linen closet room #6121 were loose. These observations were made in the presence of Employee #9 who acknowledged the findings	L 292	3243.3 Nursing Facilities Response to findings rooms # 6144 & 6121 1. The Maintenance staff took immediately action with tightening and repairing all identified loose handralls noted across from room #6144 and next to the linen closet near room #6121. 2. There were no residents affected by this deficient practice. A facility wide inspection was conducted by the Maintenance staff to ensure that all corridor handralls are firmly secured. 3. The Director of Plant Operations conducted training with Maintenance staff on Corridors having firmly secured handralls. Weekly Ambassador and monthly Environment of Care (EOC) rounds will be conducted. 4. All findings will be reported to the QA Committee by the Director of Plant Operations until 100% compliance is met for (3) consecutive months.	6/16/16 6/21/16 7/15/16
L 410	Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on June 16, 2016 between 10:00 AM and 2:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services to maintain a sanitary environment as evidenced by exhaust vents that failed to provide suction in three (3) of 37 resident's rooms, dusty window blinds and over-the-bed light fixtures in 11 of 37 resident's rooms, step-on trash cans that failed to open in three (3) of 37 resident's rooms, a	L 410		

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) L 410 Continued From page 41 L 410 3256,1 Nursing Facilities Response to findings #1 -8 defective bed in one (1) of 37 resident 's rooms, over-the-bed light fixtures that did not illuminate in There were no residents affected by the result of this 6/16/16 observation. All identified exhaust vents that did not four (4) of 37 resident 's rooms, a faulty toilet in suction in rooms #6144, 6131 & 5153 were one (1) of 37 resident 's rooms, a broken heating immediately corrected. unit in one (1) of 37 resident's rooms, and marred walls in seven (7) of 37 resident 's rooms. Window blinds and over bed lights with dust in rooms 6/16/16 # 6131, 6123, 5157, 5154, 5144, 5143, 5133, 5125, 4143, 4127, & 4113 were corrected by EVS. The findings include: Non-functional step on trash cans in rooms #5153, 6/17/16 5143, & 5133 were removed and replacements were Exhaust vents were not suctioning in three (3) ordered on 6/17/16. of 37 resident's rooms surveyed including Blo-med was notified regarding the malfunction of the 6/17/16 rooms #6144, #6131 and #5153. top of bed in room #4130. Bulbs and ballasts were changed for non-functional over bed light fixtures in rooms #6142, 5154, 4156, & 4127. Facility plumber 2. Window blinds and over-the-bed light fixtures repaired failed flushing toilet in room #5131 and cover were soiled with dust in 11 of 37 resident's to heating system in room #6131 was immediately rooms including rooms #6131, 6123, 5157, 5154, tightened and addressed by Engineering Department. 5144, 5143, 5133, 5125, 4143, 4127, and #4113. Marred walls in rooms #5154, 5153, 5125, 4156, 4154, 8/11/16 4139 & 4127 will be repaired by outside contractor. 3. Step-on trash cans were not functioning as intended as the lids would not open in three (3) of A complete audit was conducted of all rooms on the 7/13/16 4th, 5th, and 6th floors on 7/13/16 to ensure that all 37 resident's rooms including rooms #5153, #5143 walls are clear, exhaust vents were suctioned, window and #5133. blinds are dust free, trash cans, light fixtures are functional, operable toilets and heating system covers. 4. The top of the bed in room #4130 would not 3. The Director of Plant Operations conducted training adjust when that function was initiated and failed to 7/14/16 with both Housekeeping and Maintenance staff about operate as intended, one (1) of 37 resident's rooms and reporting the identified deficient practices and surveyed. 7/15/16 correcting immediately. Weekly Ambassador and monthly Environment of Care (EOC) Rounds will be 5. The over-the-bed light fixture did not light up conducted. when tested in resident's rooms #6142, All findings will be reported to the QA committee by the #5154, #4156, #4127, four (4) of 37 Director of Plan Operations until 100% compliance is resident's rooms. met for 3 consecutive months. 6. The toilet in room #5131, one (1) of 37 resident's rooms failed to flush when tested on several occasions. 7. The cover to the heating system in room

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD02-0024 B. WING 06/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 410 Continued From page 42 L 410 #6131 was completely separated from the unit and needed to be secured, one (1) of 37 resident's rooms surveyed. 8. Walls in seven (7) of 37 resident's rooms were marred including rooms #5154, #5153, #5125, #4156, #4154, #4139 and #4127. These observations were made in the presence of Employee #9 who acknowledged the findings. L 442 L 442 3258.13 Nursing Facilities 3258.13 Nursing Facilities Response to finding #1 The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe No residents were affected by this observation. 7/14/16 operating condition. Vendor was notified and conducted an inspection of the identified power cord that was not completely This Statute is not met as evidenced by: insulated. Based on observations made on June 13, 2016 at approximately 9:30 AM, it was determined that the Plugs were purchased on 6/29/16 and a complete 7/13/16 audit was conducted of all kitchen equipment to facility failed to maintain essential kitchen ensure safe operating conditions on 7/13/16. equipment in safe working condition as evidenced by a power cord from one (1) of two (2) grease Monthly EOC inspections will be conducted by the 7/15/16 fryers that was not completely insulated. Director of Plant Operations. Staff was educated on maintaining essential mechanical and electrical The findings include: equipment is safe in operable condition. All monthly inspection findings will be reported to the The power cord from one (1) of two (2) grease QA committee by the Director of Plant Operations until fryers was not fully insulated and presented a safety 100% compilance is met for three consecutive months. hazard to staff. These observations were made in the presence of Employee #8 who acknowledged the findings.

5/29/2018 Request Absence

Employee Self Service







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Request Absence

Absence Type: A-Compensatory Time

Reason Comp Time Off

Start Date 05/29/2018

End Date 05/29/2018

Additional Information

Start Date - Start Time 11:30

End Date - End Time 3:30

Total Hrs. of Absence 4.000000

Comments I need to pick up my orthotic inserts. I was hoping to go today, so as not

to interfere with the next survey. Let me know

View Requests